Completed applications must be forwarded to your Department for approval. Approved applications should be forwarded by your Department to the attention of Brad Pierson, Peoria Area EMS System Office, 605 NE Jefferson St. Peoria, IL 61603.

EMS Office Use Only

Received _____

Entered into Database _____

Entered By _____

Responder Information

Please Print

Personal Information

_____

Last Name First Name Middle Name Suffix

_____

Date of Birth Gender Height Eye Color Hair Color

_____

Address Line 1

_____

Address Line 2

_____ Home Work School

City State Zip Code Address Type

_____

Home Phone Work Phone FAX Mobile/Cell

_____

Primary E-Mail Address Alternate E-mail Address

Licensure Information *– Please list all applicable licenses.*

License Name Abbreviation License Number Expiration Date Issuing Agency State

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Certifications

Title of Certification | Abbreviation | Issue Date | Expiration Date | Certification #

Agency/Hospital Affiliation Information

Agency/Hospital Name | Region | State ID # | Individual's Agency ID | Rank

Medical History *– Please note that the following information is requested in case illness/injury occurs at an incident. Providing this information is voluntary.*

Medical History: _____

Medications: _____

Allergies: _____

Physician Name _____ Blood Type _____

Emergency Contact Information *– Notification of family in case of illness or injury will be made by the individual's Agency/Hospital whenever possible, unless otherwise requested.*

Name, First Last Relationship

Street Address Line 1

Street Address Line 2

City State Zip Code

Home Phone Work Phone Cell/Mobile

I attest that the above information is true and accurate to the best of my knowledge.

Applicants Signature Date Signed

Having reviewed the information presented in this document, I find that the applicant holds current certifications and licenses as presented in the application.

Authorizing Signature – Training Officer Printed Name Date Signed

I request that the applicant represented on this application be issued an identification badge and entered into the Responder database maintained by OSF Saint Francis Medical Center, Peoria EMS System. I attest that the individual is a member of this Department/Organization. I will confiscate the ID badge and notify the Peoria Area EMS system Office if this application separates from my Department/Organization.

Authorizing Signature – Chief of Department Printed Name Date Signed

Name of Department Contact Phone Number